

# Illinois Health Information Exchange Authority's: ILHIE Connect Opt-Out Form



The Illinois Health Information Exchange Authority's ILHIE Connect ("ILHIE Connect") service is a statewide, secure electronic network that uses modern technology so that your doctors, specialists, hospitals, clinics, laboratories, pharmacies and health insurance plans ("ILHIE Connect Users") can share a summary of your electronic health information for authorized purposes like assisting with your treatment, payment and health care operations. To learn more about ILHIE Connect, visit [www.hie.illinois.gov](http://www.hie.illinois.gov). Please read the "Notice to Patients Regarding the Illinois Health Information Exchange and ILHIE Connect" then, **if you decide you want to opt out of ILHIE Connect for the health care information held by the health care provider identified below, complete and sign this form.**

## I Choose to Opt-Out of ILHIE Connect.

By signing below, I confirm that I want to opt out of ILHIE Connect for the health care information held by the provider identified below. By choosing to opt out, I understand that none of my health information held by the health care provider identified below will be available through ILHIE Connect to other ILHIE Connect Users, even in the case of a life-threatening emergency. I understand that even if I opt out of sharing information through ILHIE Connect, my health information that is shared as required or permitted by law, such as public health data, may still be shared through the Illinois Health Information Exchange ("ILHIE").

I understand that I can change my mind at any time and that I can participate in ILHIE Connect by completing the "ILHIE Connect Opt-In Form," available from my health care provider or at <http://www.illinois.gov/sites/ilhie/Pages/ILHIEPatientParticipation.aspx>.

Please Note: Opting out of ILHIE Connect does not mean that you have opted out of participation in any other health information exchange. Ask your health care provider if they participate in any other health information exchanges and if you need to complete an additional opt-out form.

### Complete all of the following information:

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Previous Last Name: \_\_\_\_\_ Birth Date: (Ex. 01/01/1990) \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number 1: \_\_\_\_\_ Phone Number 2: \_\_\_\_\_

Email Address \_\_\_\_\_ Last Four (4) Digits of Social Security Number (if available): \_\_\_\_\_

### Health Care Provider Information:

Provider name: \_\_\_\_\_

Provider address and phone number: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the patient is 12 years of age or over, the patient must sign the form. If the patient is 11 years of age or under, the patient's parent or legal guardian must sign the form. A guardian or personal representative with authority to make health care decisions on behalf of the patient may sign this form. (Check, if applicable: \_\_\_\_\_ Parent \_\_\_\_\_ Legal Guardian.)

**Submission of form:** You may submit this form one of two ways:

**Option 1:** Give this completed form to your health care provider identified above, or

**Option 2:** Complete the form and have the form notarized. Then send the form to the ILHIE Authority. The ILHIE Authority will make every effort to process your request to participate within 3 business days of receipt by one of the following means:

- Mail: Privacy Officer  
Illinois Health Information Exchange Authority  
James R. Thompson Center  
100 W. Randolph Street, Suite 4-750  
Chicago, IL 60601
- Facsimile: 312-814-5073
- Scan and email: [ILHIE.Privacy@Illinois.gov](mailto:ILHIE.Privacy@Illinois.gov)
- Questions? Contact [ILHIE.Privacy@Illinois.gov](mailto:ILHIE.Privacy@Illinois.gov)

If using **Option 2**, the following section must be completed by a Notary Public:

### Acknowledgment

State of Illinois

County of \_\_\_\_\_

This instrument was acknowledged before me on

\_\_\_\_\_ (date) by

\_\_\_\_\_ (name of person)  
who provided me with photographic proof of identification.

(seal)

\_\_\_\_\_  
Signature of Notary Public